

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2009
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NAME OF PROVIDER OR SUPPLIER SILVER RIDGE HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1151 TORREY PINES DR. LAS VEGAS, NV 89146
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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification and complaint survey conducted at your facility on 1/13/2009 through 1/16/2009. The census at the time of the survey was 131. The sample size was 24 including 3 closed records. There was one complaint investigated during the survey: CPT #NV20356 was Unsubstantiated The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		

*For re-assessment
Cand. Can. 2/17/09*

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Executive Director	TITLE	(X6) DATE 02-06-09
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of 24 sampled residents (#1).</p> <p>Findings include:</p> <p>1. Resident #1 was admitted to the facility on 1/6/09 with diagnoses including Congestive Heart Failure, Osteoarthritis, Atrial Fibrillation, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.</p> <p>Resident #1 was admitted to the facility with an indwelling Foley catheter as documented on the resident's Nursing Admission Assessment form dated 1/6/09. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.</p> <p>At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated if a resident with an indwelling Foley catheter was admitted to the facility, a Catheter Need Evaluation and Care Plan form was completed to determine the need for the catheter. Regional Director Consultant indicated the form also acted as the resident's care plan.</p>	F 279	<p>F279—Resident #1 discharged from the facility on 1/23/09.</p> <p>A catheter need evaluation & care plan form was completed for this resident on 1/16/09.</p> <p>A 100% audit of all residents with foley catheters was conducted on 1/20/09. All residents had a catheter need evaluation & care plan form in place.</p> <p>Nursing administration will audit all new orders each business day, all foley catheter orders will have a chart review to ensure a catheter need evaluation and care plan form was completed. Licensed nurses were inserviced on 1/20/09 on the use of the catheter need evaluation & care plan form as well as the P & P. DON or designee to do a random chart check of residents with foley catheter to ensure catheter need evaluation & care plan forms are in place and report to CQI committee throughout the year.</p>		01-20-09

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F 279	Continued From page 2 No documented evidence a Catheter Need Evaluation and Care Plan form was completed for Resident #1. On 1/16/2009 in the afternoon, the Director of Nursing confirmed Resident #1 did not have a catheter assessment completed and no indwelling catheter care plan initiated.	F 279			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to medically justify indwelling catheter use and provide appropriate catheter care for 4 of 24 sampled residents (#1, #21, #12, #19). Finding include: 1. Resident #1 was admitted on 1/6/09 with diagnoses including Congestive Heart Failure, Osteoarthritis, Atrial Fibrillation, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. Resident #1 was admitted to the facility with an indwelling Foley catheter as documented on the resident's Nursing Admission Assessment form	F 315	F315-- Resident #1 discharged from the facility on 1/23/09. A catheter need evaluation & care plan form was completed for this resident on 1/16/09. A 100% audit of all residents with foley catheters was conducted on 1/20/09. All residents had a catheter need evaluation & care plan form in place. Nursing administration will audit all new orders each business day, all foley catheter orders will have a chart review to ensure a catheter need evaluation and care plan form was completed. Licensed nurses were inserviced on 1/20/09 on the use of the catheter need evaluation & care plan form as well as the P & P. DON or designee to do a random chart check of residents with foley catheter to ensure orders are in place and report to CQI committee throughout the year.		01-20-09

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F 315	<p>Continued From page 3</p> <p>dated 1/6/09. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.</p> <p>At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated if a resident with an indwelling Foley catheter was admitted to the facility, a Catheter Need Evaluation and Care Plan form was completed to determine the need for the catheter. The Regional Director Consultant indicated the form also acted as the resident's care plan.</p> <p>No documented evidence of a Catheter Need Evaluation and Care Plan form was completed for Resident #1. On 1/16/2009 in the afternoon, the Director of Nursing confirmed Resident #1 did not have a catheter assessment completed and no indwelling catheter care plan initiated.</p> <p>2. Resident #21 was admitted on 12/17/2008, with diagnoses including Pneumonia, Urinary Tract Infection, Muscle Weakness, Hypertension, Severe Glaucoma, and Anxiety.</p> <p>Resident #21 was admitted with a Foley catheter as documented on the Nursing Admission Assessment form dated 12/17/2008. From 1/13 to 1/16/2009, Resident #1 was observed to have a Foley catheter with yellow urine present in the Foley bag.</p> <p>There was no documented evidence Resident #21 had an order for a Foley catheter. Resident #21's Catheter Need Evaluation and Care Plan form dated 12/17/08 documented:</p> <p>- "...Change catheter and drainage per MD</p>	F 315	<p>Resident #21—An order for the foley catheter was obtained on 1/16/09. An audit of 100% of all residents with foley catheters was conducted on 1/20/09. Nursing administration will audit all new orders each business day, all foley catheter orders will have a chart review to ensure that all orders were obtained to manage said catheter. Licensed nurses were inserviced on 1/20/09 on the foley catheter P & P. DON or designee to do a random chart check of residents with foley catheter to ensure medical justification and catheter management plan are in place and report to CQI committee throughout the year.</p>	01-20-09	

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SILVER RIDGE HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1151 TORREY PINES DR.
LAS VEGAS, NV 89146

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F 315	<p>Continued From page 4 (Medical Doctor) orders..."</p> <p>There was no documented evidence Resident #21 had specific physician orders for Foley catheter care and maintenance.</p> <p>At 11:00 AM on 1/16/2009, the Regional Director Consultant indicated physician orders were needed for Foley catheter insertions. Also, Physician orders were needed for specific care and maintenance for each resident who had an indwelling catheter.</p> <p>3. Resident #12 was a 91 year-old female resident initially admitted to the facility on 12/1/07 and recently re-admitted on 1/7/09, with diagnoses including Hypertension, History of Stomach Cancer, Urosepsis, Methicillin-Resistant Staphylococcus Aureus, Bacteremia, Vancomycin-Resistant Enterococcus, Muscle Weakness, Impaired Ambulation, Chronic Obstructive Pulmonary Disease, Shortness of Breath, and Chronic Pain Syndrome.</p> <p>The History and Physical Examinations dated 2/19/08 and 9/3/08, contained in the resident's closed records indicated no evidence of a diagnosis which revealed a diagnosis that required an indwelling catheter.</p> <p>The resident had a third re-admission on 1/7/09. The Nursing Admission Assessment dated 1/7/09, indicated the resident was transferred from Valley Hospital with a Foley Catheter and no diagnosis was evident in the space provided for its use.</p> <p>As noted in the facility's nursing assessment,</p>	F 315	<p>Resident#12—Foley catheter removed on 1/14/09. An audit of 100% of all residents with foley catheters was conducted on 1/20/09. All residents had a catheter need evaluation & care plan form in place. Nursing administration will audit all new orders each business day, all foley catheter orders will have a chart review to ensure a catheter need evaluation and care plan form was completed. Licensed nurses were inserviced on 1/20/09 on the use of the catheter need evaluation & care plan form as well as the P & P. DON or designee to do a random chart check of residents with foley catheter to ensure all forms and orders are in place and report to CQI committee throughout the year.</p>	01-20-09

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F 315	<p>Continued From page 5</p> <p>when a resident is admitted with a Foley Catheter, staff are to "proceed with catheter orders and care plan development."</p> <p>The resident's Bowel & Bladder Assessment and Management document dated 1/7/09, indicated the resident was a possible candidate for re-training or individual training for bowel and/or bladder re-training. The two page assessment document indicated no documented evidence of the resident's current status of having an indwelling catheter. It was noted on the second page that the resident was alert and cognitively intact and the preferred mode for the resident was to be a toilet.</p> <p>A Physician Progress Note dated 1/8/09, indicated the resident's initial assessment included a plan to admit the resident to the facility, intravenous antibiotics, PT/OT (physical therapy/occupational therapy) evaluation and treatment to improve the patient's functional ability and independence, and nutritional support.</p> <p>Other documentation of the resident's plan were noted, but not readable. There was no documented evidence in the assessment which revealed any catheter orders.</p> <p>The resident's Interim Plan of Care indicated the word "Foley" under Bladder/Bowel Status (#6 in the plan). There was no plan of care or directions of care for staff documented in the plan of care.</p> <p>4. Resident #19 was a 90 year-old female resident initially admitted on 11/12/08 and recently re-admitted on 1/8/09, with diagnoses including Depression, Dementia, Hypertension,</p>	F 315			

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F 315	<p>Continued From page 6</p> <p>Coronary Artery Disease, Congestive Heart Failure, Muscle Weakness, Gait Impairment, Dysphagia, Symbolic Dysfunction, C. Difficile Colitis, Metabolic Myopathy, Recurrent Falls, Chronic Gastritis, Diverticulitis, Osteoarthritis, Renal Insufficiency, Hyperkalemia, Hyponatremia, and Anemia.</p> <p>The current History and Physical Examination dated 1/9/09, indicated the resident was re-admitted to the facility following a transfer from Southern Hills Hospital due to chest congestion. There was no mention of the resident having an indwelling catheter and/or diagnosis which required the resident to have a catheter.</p> <p>The Nursing Admission Assessment dated 1/8/09, indicated a Foley Catheter was present upon the resident's re-admission and no diagnosis was evident in the space provided for its use.</p> <p>The facility's Medication Record for 1/2009, following the re-admission, indicated an order on 1/8/09 for Foley Catheter care every shift. There was diagnosis indicated on the record which supported the use of the catheter or the actual care required.</p> <p>The resident's Interim Plan of Care dated 1/8/09, indicated the word "Foley Catheter" under the "Toileting" section. However, there was no documented evidence of a plan of care or directions of care for staff documented in the plan of care.</p> <p>A Physician Telephone Order dated 1/14/09, indicated an order to D/C (discontinue) Foley Catheter. This order was written following an</p>	F 315	<p>Resident#19—Foley catheter removed on 1/14/09. An audit of 100% of all residents with foley catheters was conducted on 1/20/09. All residents had a catheter need evaluation & care plan form in place. Nursing administration will audit all new orders each business day, all foley catheter orders will have a chart review to ensure a catheter need evaluation and care plan form was completed. Licensed nurses were inserviced on 1/20/09 on the use of the catheter need evaluation & care plan form as well as the P & P. DON or designee to do a random chart check of residents with foley catheter to ensure all forms and orders are in place and report to CQI committee throughout the year.</p>	01-20-09	

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If continuation sheet Page 8 of 10

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F 371	Continued From page 8 2. Deserts for the residents in the walk-in refrigeration unit were not covered. 3. There was a broken light bulb in the walk-in refrigerator. 4. The hand wash sink by the dishwasher was not secured to the wall.	F 371	3. The broken light bulb found in the walk-in refrigerator was repaired immediately. The dietary supervisor did a safety walk-through of the dietary department to determine if any other lights were out, broken, or needed any repair. Weekly safety walk-throughs will be done by the Diet Tech and repairs will be made as needed. The Dietary Supervisor or designee will monitor this process with weekly spot checks and report any areas of concern during CQI/QA		01-22-09
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	4. The hand washing sink was secured to the wall. The dietary supervisor completed a safety walk-through of the entire department to identify any areas needed repair. The diet tech will do a weekly safety walk-through of the dietary department noting any needed repairs and notify the maintenance department. The Dietary Supervisor or designee will monitor dietary department safety issues with periodic spot checks and report any areas of challenge during CQI/QA.		01-22-09

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F 431	<p>Continued From page 9</p> <p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure expired medications were discarded in a timely manner.</p> <p>Findings include:</p> <p>On 1/14/09 at 3:40 PM, the locked medication box in the Medication Room #1 refrigerator contained:</p> <p>a) a one milliliter vial of Lorazepam (2 milligrams per milliliter) with an expiration date of 11/07; b) seven one milliliter vials of Lorazepam (2 milligrams per milliliter) with an expiration date of 4/08; and c) four one milliliter vials of Lorazepam (2 milligrams per milliliter) with an expiration date of 9/08.</p> <p>Note: The vials with the expiration date of 4/08 were intermingled with two vials displaying an expiration date of 2011, in a small "ziplock" bag.</p> <p>On 1/14/09 at 3:45, Employee #1 acknowledged the vials had expired and should have been removed and discarded on the last day of the month on the label.</p>	F 431	<p>F431—The medications were removed on 1/14/09. Licensed nursing staff was inserviced on 1/20/09 on the storage of narcotics. All medication refrigerators were inspected and no medications are currently stored in the lock boxes as of 1/20/09.</p> <p>Nursing administration will conduct weekly inspections of the narcotic lock boxes in the refrigerators for any medications that are expired or were prescribed for a currently discharged patient.</p> <p>DON or designee to monitor by random inspection of narcotic lock boxes and report to CQI throughout the year.</p>	01-20-09	

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